

Subject: Studies in the News: (January 14, 2011)



Studies in the News for



California Department of Mental Health

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CONTENTS

ARIZONA TRAGEDY-COMMENTARY

[Identifying the Violent Mentally Ill is a Challenge, Experts Say](#)

AGING AND MENTAL HEALTH

[Behavioural and Psychological Symptoms in Older Population without Dementia](#)

ANTIPSYCHOTICS

[Bipolar Disorder Treated with Atypical Antipsychotics](#)

CHILDREN AND ADOLESCENTS

[Admissions to Acute Adolescent Psychiatric Units](#)

[Barriers and Facilitators to Mental Health Seeking in Young People](#)

CRIMINAL JUSTICE

[Information Sharing in Criminal Justice-Mental Health Collaborations](#)

DUAL ELIGIBLE HEALTH INSURANCE

[The “Dual Eligible” Opportunity: Improving Care and Reducing Costs](#)

FOSTER CARE

[Transition to Adulthood: How States can Support Older Youth in Foster Care](#)

HOMELESSNESS

[Hunger, Homelessness Still Major Challenges in U.S. Cities](#)

INTEGRATED HEALTH CARE

[Integrated Medicine: Enhancing Quality in Primary Care](#)

[Model for Integrating Physicians into Accountable Care Organizations](#)

[Team Care Helps Patients with Depression, Health Issues](#)

INTERVENTIONS

[Effect of a Healthy Lifestyle Intervention for People with Severe Mental Disorders](#)

[Working towards Wellness](#)

JUVENILE JUSTICE

[Improving the Effectiveness of Juvenile Justice Programs](#)

[Substance Use and Delinquent Behavior among Serious Adolescent Offenders](#)

SUICIDE PREVENTION

[Repetition of Suicide Attempts across Episodes of Severe Depression](#)

[Suicidal Intention, Psychosocial Factors, and Referral to Further Treatment](#)

VETERANS

[After Combat: Mental Health, Use of Mental Health Services](#)

[Returning Veterans from Iraq and Afghanistan in Mental Health Treatment](#)

NON PROFIT RESOURCE CENTER-GRANT WRITING

CONFERENCES, MEETINGS, SEMINARS

[Reinvigorating Primary Care in the Form of Patient-Centered Medical Home](#)

[25th Conference Annual San Diego International Conference on Child and Family Maltreatment.](#)

[Annual Meeting American College of Psychiatrists.](#)

ARIZONA TRAGEDY-COMMENTARY

“Identifying the Violent Mentally Ill is a Challenge, Experts Say.” By Melissa Healy and Eryn Brown, Los Angeles Times. (The Times, Los Angeles, California) January 11, 2011. 3p.

[“In the best of times and most favorable of circumstances, it's tricky business to identify whether a person who is mentally ill might become violent, so that those in his path can be protected from potential harm and he can get the treatment he needs. But with community mental health services stretched taut by budget cuts and growing need, these are not the best of times, say many experts at the intersection of mental health and public safety. Nor were circumstances ideal to single out Jared Lee Loughner — the suspect in Saturday's Tucson shooting rampage — as a clear-cut case of someone about to become violent.”]

Full text:

<http://articles.latimes.com/2011/jan/11/health/la-he-mental-health-20110111>

[\[Back to Top\]](#)

AGING AND MENTAL HEALTH

“Behavioural and Psychological Symptoms in the Older Population without Dementia – Relationship with Socio-demographics, Health and Cognition.” By Rianne van der Linde and others, University of Cambridge. IN: BMC Geriatrics, vol. 10, no. 87 (2010) pp. 1-10.

[“Behavioural and psychological symptoms are associated with dementia, but are also present in a significant number of the older population without dementia. Here we explore the distribution of behavioural and psychological symptoms in the population without dementia, and their relationship with domains and severity of health and cognitive impairment.

Methods: The Medical Research Council Cognitive Function and Ageing Study is a two-phase longitudinal study of ageing representative of the population aged 65 and over of England and Wales. A subsample of 1781 participants without a study diagnosis of dementia was included in this study. Information on symptoms including depression, apathy, anxiety, feelings of persecution, hallucination, agitated behaviour, elation, irritability, sleep problems, wandering, confabulation and misidentification, cognitive function, health related factors and socio-demographic information was extracted from interviews with participants and knowledgeable informants. Participants were classified according to the Mini-Mental State Examination and by criteria for subtypes of mild cognitive impairment (MCI). The prevalence of behavioural and psychological symptoms and associations with cognitive function, health and socio-demographics was examined. Co-occurrence of symptoms was tested using factor analysis.

Results: Most symptoms were reported more frequently in those with more severe cognitive impairment. Subjective memory complaints were the strongest independent predictor of reported symptoms, and most were reported more often in those classified as having MCI than in those with cognitive impairments that did not meet the MCI criteria. The pattern of co-occurrence of symptoms is similar to that seen in dementia. Conclusions: Our results highlight that behavioural and psychological symptoms are prevalent in the cognitively impaired older population, and partly explain the variation observed in previous cohorts of individuals with MCI. Behavioural and psychological symptoms offer a target for intervention and so are an important consideration in the assessment of cognitively impaired older people.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2318-10-87.pdf>

[\[Back to Top\]](#)

ANTIPSYCHOTICS

“One-year risk of psychiatric hospitalization and associated treatment costs in Bipolar disorder treated with atypical antipsychotics: a retrospective claims Database analysis” By Edward Kim, Bristol-Meyers Squibb, Plainsboro, New Jersey, and others. IN: *BMC Psychiatry*, vol. 11, no. 6 (January 7, (2011) pp. 1-27.

[“This study compared 1-year risk of psychiatric hospitalization and treatment costs in commercially insured patients with bipolar disorder, treated with aripiprazole, ziprasidone, olanzapine, quetiapine or risperidone.

METHODS: This was a retrospective propensity score-matched cohort study using the Ingenix Lab/Rx integrated insurance claims dataset. Patients with bipolar disorder and 180 days of pre-index enrollment without antipsychotic exposure who received atypical antipsychotic agents were followed for up to 12 months following the initial antipsychotic prescription. The primary analysis used Cox proportional hazards regression to evaluate time-dependent risk of hospitalization, adjusting for age, sex and pre-index hospitalization. Generalized gamma regression compared post-index costs between treatment groups.

RESULTS: Compared to aripiprazole, ziprasidone, olanzapine and quetiapine had higher risks for hospitalization (hazard ratio 1.96, 1.55 and 1.56, respectively; $p < 0.05$); risperidone had a numerically higher but not statistically different risk (hazard ratio 1.37; $p = 0.10$). Mental health treatment costs were significantly lower for aripiprazole compared with ziprasidone ($p = 0.004$) and quetiapine ($p = 0.007$), but not compared to olanzapine ($p = 0.29$) or risperidone ($p = 0.80$). Total healthcare costs were significantly lower for aripiprazole compared to quetiapine ($p = 0.040$) but not other comparators.

CONCLUSIONS: In commercially insured adults with bipolar disorder followed for 1 year after initiation of atypical antipsychotics, treatment with aripiprazole was associated with a lower risk of psychiatric hospitalization than ziprasidone, quetiapine, olanzapine and risperidone, although this did not reach significance with the latter. Aripiprazole was also associated with significantly lower total healthcare costs than quetiapine, but not the other comparators.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-11-6.pdf>

[\[Back to Top\]](#)

CHILDREN AND ADOLESCENTS

“Admissions to acute adolescent psychiatric units: A prospective study of clinical severity and outcome.” By Ketil Hanssen-Bauer, Centre for Child and Adolescent Mental Health, Eastern and Southern Norway, and others. **IN: International Journal of Mental Health Systems, vol. 5, no. 1 (January 6, 2011) pp. 1-32.**

[“Several countries have established or are planning acute psychiatric in-patient services that accept around-the-clock emergency admission of adolescents. Our aim was to investigate the characteristics and clinical outcomes of a cohort of patients at four Norwegian units.

Methods

We used a prospective pre-post observational design. Four units implemented a clinician-rated outcome measure, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), which measures mental health problems and their severity. We collected also data about the diagnoses, suicidal problems, family situations, and the involvement of the Child Protection Service. Predictions of outcome (change in HoNOSCA total score) were analysed with a regression model.

Results

The sample comprised 192 adolescents admitted during one year (response rate 87%). Mean age was 15.7 years (range 10-18) and 70% were girls. Fifty-eight per cent had suicidal problems at intake and the mean intake HoNOSCA total score was 18.5 (SD 6.4). The largest groups of main diagnostic conditions were affective (28%) and externalizing (26%) disorders. Diagnoses and other patient characteristics at intake did not differ between units. Clinical psychiatric disorders and developmental disorders were associated with severity (on HoNOSCA) at intake but not with outcome. Of adolescents 16 years or older, 33% were compulsorily admitted. Median length of stay was 8.5 days and 75% of patients stayed less than a month. Compulsory admissions and length of stay varied between units. Mean change (improvement) in the HoNOSCA total score was 5.1 (SD 6.2), with considerable variation between units. Mean discharge score was close to the often-reported outpatient level, and self-injury and emotional symptoms were the most reduced symptoms during the stay. In a regression model, unit, high HoNOSCA total score at intake, or involvement of the Child Protection Service predicted improvement during admission.

Conclusions

Acute psychiatric in-patient units for adolescents effectively meet important needs for young people with suicidal risks or other severe mental health problems. These units may act in suicide prevention, stabilizing symptom severity at a lower level within a short stay. It is important to explore the differences in outcome, compulsory admissions, and length of stay between units.”]

Full text at:

<http://www.ijmhs.com/content/pdf/1752-4458-5-1.pdf>

[\[Back to Top\]](#)

“Perceived barriers and facilitators to mental health help-seeking in young People: a systematic review.” By Amelia Gulliver and others, the Australian National University. IN: BMC Psychiatry, vol. 10, no. 113 (December 30, 2010)pp. 1-26.

[“Adolescents and young adults frequently experience mental disorders, yet tend not to seek help. This systematic review aims to summarise reported barriers and facilitators of help seeking in young people using both qualitative research from surveys, focus groups, and interviews and quantitative data from published surveys. It extends previous reviews through its systematic research methodology and by the inclusion of published studies describing what young people themselves perceive are the barriers and facilitators to help-seeking for common mental health problems.

Methods

Twenty two published studies of perceived barriers or facilitators in adolescents or young adults were identified through searches of PubMed, PsycInfo, and the Cochrane database. A thematic analysis was undertaken on the results reported in the qualitative literature and quantitative literature.

Results

Fifteen qualitative and 7 quantitative studies were identified. Young people perceived stigma and embarrassment, problems recognising symptoms (poor mental health literacy), and a preference for self-reliance as the most important barriers to help-seeking. Facilitators were comparatively under-researched. However, there was evidence that young people perceived positive past experiences, and social support and encouragement from others as aids to the help-seeking process.

Conclusions

Strategies for improving help-seeking by adolescents and young adults should focus on improving mental health literacy, reducing stigma, and taking into account the desire of young people for self-reliance

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-10-113.pdf>

[\[Back to Top\]](#)

CRIMINAL JUSTICE

Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPPA and other Privacy Laws. By John Petrila, University of South Florida and Hallie Fader-Towe, Council of State Governments Justice Center. (The Council, New York, New York) 2010. 46 p.

[“Individuals with mental illnesses are overrepresented at every stage of the criminal justice process. In response, many jurisdictions have developed a range of policy and

programmatic responses that depend on collaboration among the criminal justice, mental health, and substance abuse treatment systems.¹ A critical component of this cross-system collaboration is information sharing, particularly information about the health and treatment of people with mental illnesses who are the focus of these responses. At the individual level, health information is essential to provide adequate assessment and treatment. At the program level, it can be used to identify target populations for interventions, evaluate program effectiveness, and determine whether programs are cost-efficient. However, legal and technical barriers, both real and perceived, often prevent a smooth exchange of information among these systems and impede identifying individuals with mental illnesses and developing effective plans for appropriate diversion, treatment, and transition from a criminal justice setting back into the community.

Understanding the legal framework of information sharing is the crucial first step for jurisdictions seeking to design and implement effective criminal justice-mental health collaborations. This guide supports that first step by introducing how federal and state laws are likely to influence practitioners' responses. Federal law shapes what is permissible at the state or local level, primarily through the basic privacy rules for "protected health information" (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)² and substance abuse treatment information under 42 CFR Part 2, a portion of the Code of Federal Regulations addressing public health."]

Full text at:

http://consensusproject.org/jc_publications/infosharing/Information_Sharing_in_Criminal_Justice-Mental_Health_Collaborations.pdf

[\[Back to Top\]](#)

DUAL ELIGIBLE HEALTH INSURANCE

The "Dual Eligible" Opportunity: Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid. By Karen Davenport, Center for American Progress and others. (The Center, Washington, D.C.) December 2010. 21 p.

["The 8.8 million so-called "dual eligibles," or individuals who qualify for and are enrolled in both the Medicare and Medicaid public health insurance programs, are some of the sickest and poorest patients in our nation's health care system. Not surprisingly, they are some of the most expensive patients as well. Policymakers and program managers have long sought solutions for improving the quality and efficiency of care delivered to these individuals.

Implementation of the Affordable Care Act, the health reform law enacted in March, 2010, offers new opportunities for achieving these goals by experimenting with different approaches to see what works. One of those options is to allow the states to assume full financial and programmatic responsibility for managing the

health care of dual eligibles, in contrast to today’s practice of sharing the financial costs and management challenges related to these patients across two programs—one managed by the states and the federal government (Medicaid) and one managed only by Washington (Medicare)—each with different coverage and payment parameters. Other approaches may be identified and tested through demonstration programs authorized by the new law.

These opportunities must be pursued, however, only under circumstances that lead to better health outcomes for this group of particularly sick and poor individuals. The Centers for Medicare and Medicaid Services, or CMS, which manages the two public health insurance programs at the Department of Health and Human Services, has two new avenues for improving care for dual eligibles. One is the new Federal Coordinated Health Care Office, which is charged with improving integration between the two programs, eliminating cost-shifting between Medicare and Medicaid, and improving quality of care. And the other is the Center for Medicare and Medicaid Innovation, which is charged with identifying a range of pilot projects related to the reform of health care payment and delivery systems, with particular emphasis on improving the coordination, quality and efficiency of care—steps that can benefit dual eligibles in particular.”]

Full text at:

http://www.americanprogress.org/issues/2010/12/pdf/dual_eligibles.pdf

[\[Back to Top\]](#)

FOSTER CARE

Transition to Adulthood: How States can Support Older Youth in Foster Care. By Susan Golonka, National Governors’ Association for Best Practices. (The Association, Washington, D.C.) December 2010. 44 p.

[“The number of youth aging out* of foster care has increased every year since 2001. In the past five years alone, more than 100,000 youth left the foster care system because of age limits or because they “aged out.” This population, although small in number, has a high economic cost to state governments and society as a whole. Yet, because there are relatively few of these young people, states that invest in them can make a large positive impact without incurring great cost. Youth who age out of the foster care system are more likely than their non-foster care peers to be involved with the criminal justice system, have low educational attainment, become pregnant, experience homelessness, and lack health insurance. One study showed, for example, that a mere 6 percent of foster youth had completed a two- or four year postsecondary degree by age 23 or 24, compared with 29 percent of their peers.^{3A} A startling 77 percent of female foster youth became pregnant by age 23 or 24, compared with just 40 percent of their peers in the general population. In general, individuals who leave foster care at age 18 are more apt to grow into adults who will require long-term government support and who experience lifelong difficulties.

Youth development experts and child welfare researchers point to evidence showing that a state's best chance to adequately prepare foster youth for adulthood is to undertake complementary strategies in education, employment, health care, and other areas. Many states, including Arizona, California, Colorado, Connecticut, and Massachusetts, have implemented promising approaches in these areas. They have shown that both foster youth and states can benefit from a comprehensive approach that helps these young people successfully transition to adulthood. In fact, some research shows that concerted (and relatively inexpensive) investments in foster youth's long-term success could potentially save the nation \$5.7 billion for each annual cohort of youth transitioning out of foster care by reducing the demand for public spending that correlates with poor education and low employment, such as welfare assistance and criminal justice expenditures. Many of the strategies described in this report have little or no cost; involve getting existing systems, such as education and health, to work more collaboratively; and leverage currently available federal and private funding in new or different ways.”]

Full text at:

<http://www.nga.org/Files/pdf/1012FOSTERCARE.PDF>

[\[Back to Top\]](#)

HOMELESSNESS

Hunger, Homelessness Still Major Challenges in U.S. Cities: Majors Issue Annual Report on Hunger, Homelessness in 27 Major Cities. Press Release. (United States Conference of Majors, Washington, D.C.) December 21, 2010, 2 p.

[“U.S. Conference of Mayors (USCM) report on the status of Hunger and Homelessness in 27 cities in America (listed below) that was released today by the U.S. Conference of Mayors on a news conference call. For more than a quarter century, The Conference of Mayors has documented the magnitude of the issues of hunger and homelessness in our nation's cities, as well as efforts cities are making to address these challenges.

“While there is currently an historic effort to restore America's economy, the effects of hunger and homelessness are clearly evident in America's cities and urban centers. This is why mayors have been so proactive in supporting and encouraging local food programs and why federal programs like the Supplemental Nutrition Assistance Program (food stamps) are so critical,” said Asheville, NC Mayor Terry Bellamy who chairs the USCM Hunger and Homelessness Task Force and participated in the press conference call. “The ‘food stamp’ program is an integral safety net for hungry families in our cities. Mayors want to ensure that the recent cuts made to the food stamp program are restored; and we support the Administration's efforts in this regard. With respect to addressing homelessness, collaboration is essential. Asheville has seen a decrease in chronic homelessness due to a strong collaborative effort between local government and community partners through the implementation of the Housing First model.”

Every city surveyed reported that requests for emergency food assistance increased by an average of 24 percent across the cities over the past year. Among those requesting emergency food service, 56 percent were families and 30 percent were employed. When asked to report on the three main causes of hunger, respondents cited unemployment, housing costs and low wages.]

Full text at:

<http://www.usmayors.org/pressreleases/uploads/RELEASE%20-%20HUNGER%20%20HOMELESSNESS%202010%20FINAL.pdf>

[\[Back to Top\]](#)

INTEGRATED HEALTH CARE

“Integrative Medicine: Enhancing Quality in Primary Health Care.” By Sandra Grace and Joy Higgs, Charles Sturt University, Australia. IN: Journal of Alternative and Complimentary Medicine, vol. 16, no. 9 (September 2010) pp. 945-950.

[“Integrative medicine (IM) is an emerging model of **health** care in Australia. However, little is known about the contribution that IM makes to the quality of **health** care. The aim of the research was to understand the contribution IM can make to the quality of primary care practices from the perspectives of consumers and providers of IM. Design: This interpretive research used hermeneutic phenomenology to understand meanings and significance that patients and practitioners attach to their experiences of IM. Various qualitative research techniques were used: case studies; focus groups; and key informant interviews. Data sets were generated from interview transcripts and field notes. Data analysis consisted of repeatedly reading and examining the data sets for what they revealed about experiences of **health** care and **health** outcomes, and constantly comparing these to allow themes and patterns to emerge. Setting: The setting for this research was Australian IM clinics where general medical practitioners and CAM practitioners were co-located. Results: From the perspective of patients and practitioners, IM: (1) provided authentically patient-centered care; (2) filled gaps in treatment effectiveness, particularly for certain patient populations (those with complex, chronic **health** conditions, those seeking an alternative to pharmaceutical **health** care, and those seeking **health** promotion and illness prevention); and (3) enhanced the safety of primary **health** care (because IM retained a general medical practitioner as the primary contact practitioner and because IM used strategies to increase disclosure of treatments between practitioners). Conclusions: According to patients and practitioners, IM enhanced the quality of primary **health** care through its provision of **health** care that was patient-centered, effective (particularly for chronic **health** conditions, nonpharmaceutical treatments, and **health** promotion) and safe.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=53561318&site=ehost-live>

[\[Back to Top\]](#)

“A Model for Integrating Independent Physicians into Accountable Care Organizations.” By Mark C. Shields, Advocate Physician Partners, and others. **IN: Health Affairs, vol.30, no. 1 (January 2011) pp. 161-172.**

[“The Affordable Care Act encourages the formation of accountable care organizations as a new part of Medicare. Pending forthcoming federal regulations, though, it is unclear precisely how these ACOs will be structured. Although large integrated care systems that directly employ physicians may be most likely to evolve into ACOs, few such integrated systems exist in the United States. This paper demonstrates how Advocate Physician Partners in Illinois could serve as a model for a new kind of accountable care organization, by demonstrating how to organize physicians into partnerships with hospitals to improve care, cut costs, and be held accountable for the results. The partnership has signed its first commercial ACO contract effective January 1, 2011, with the largest insurer in Illinois, Blue Cross Blue Shield. Other commercial contracts are expected to follow. In a health care system still dominated by small, independent physician practices, this may constitute a more viable way to push the broader health care system toward accountable care.”]

Full text at or if you cannot access this article, please contact the California State Library.
<http://content.healthaffairs.org/content/30/1/161.full.pdf+html>

[\[Back to Top\]](#)

“Team Care Helps Patients with Depression, Health Issues.” By Carol M. Ostrom, **Seattle Times Health Reporter.** (The Times, Seattle, Washington) **December 29, 2010. 2 p.**

[“Depressed patients who have poorly controlled diabetes or heart disease — or both — often are some of the most unhappy and expensive patients around. But when their depression and physical problems are monitored and treated by a team of primary-care providers, these patients not only feel better, their physical condition improves significantly, researchers from the University of Washington and Group Health Cooperative reported this week in the New England Journal of Medicine.”]

Full text at:

http://seattletimes.nwsourc.com/html/localnews/2013798816_teamcare30m.html

INTERVENTIONS

“Study protocol: a randomised controlled trial investigating the effect of a healthy lifestyle intervention for people with severe mental disorders.” By Amanda Baker,

University of Newcastle, Australia, and others. IN: BMC Public Health, vol. 11, no. 10 (January 5, 2011) pp. 1-24.

[“Background: The largest single cause of death among people with severe mental disorders is cardiovascular disease (CVD). The majority of people with schizophrenia and bipolar disorder smoke and many are also overweight, considerably increasing their risk of CVD. Treatment for smoking and other health risk behaviours is often not prioritized among people with severe mental disorders. This protocol describes a study in which we will assess the effectiveness of a healthy lifestyle intervention on smoking and CVD risk and associated health behaviours among people with severe mental disorders. Methods/Design: 250 smokers with a severe mental disorder will be recruited. After completion of a baseline assessment and an initial face-to-face intervention session, participants will be randomly assigned to either a multi-component intervention for smoking cessation and CVD risk reduction or a telephone-based minimal intervention focusing on smoking cessation. Randomisation will be stratified by site (Newcastle, Sydney, Melbourne, Australia), Body Mass Index (BMI) category (normal, overweight, obese) and type of antipsychotic medication (typical, atypical). Participants will receive 8 weekly, 3 fortnightly and 6 monthly sessions delivered face to face (typically 1 hour) or by telephone (typically 10 minutes). Assessments will be conducted by research staff blind to treatment allocation at baseline, 15 weeks, and 12-, 18-, 24-, 30- and 36-months. Discussion: This study will provide comprehensive data on the effect of a healthy lifestyle intervention on smoking and CVD risk among people with severe mental disorders. If shown to be effective, this intervention can be disseminated to treating clinicians using the treatment manuals.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2458-11-10.pdf>

[\[Back to Top\]](#)

Working towards Wellness: Telephone Care Management for Medicaid Recipients with Depression Eighteen Months after Random Assignment. By Sue Kim and others, MDRC Building Knowledge to Improve Social Policy. (U.S. Dept. of Health and Human Services, Washington, D.C.) November 2010. 168 p.

[“Although many public assistance recipients suffer from depression, few receive consistent treatment. This report on a telephonic care management program in Rhode Island that tried to encourage depressed parents who were receiving Medicaid to seek treatment from a mental health professional presents results through 18 months — six months following a one-year intervention. Called “Working toward Wellness,” the program represents one of four strategies being studied in the Enhanced Services for the Hard-to-Employ Demonstration and Evaluation to improve employment for low-income parents who face serious barriers to employment. The project is sponsored by the Administration for Children and Families and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services, with additional funding from the Department of Labor. In Working toward Wellness,

master's-level clinicians (“care managers”) telephoned the study participants in the program group to encourage them to seek treatment, to make sure that they were complying with treatment, and to provide telephonic counseling. The effects of the program are being studied by examining 499 depressed Medicaid recipients with children, who were randomly assigned to the program group or the control group from November 2004 to October 2006. Participants were given a list of mental health professionals in the community from whom they could receive treatment.”]

Full text at:

http://www.acf.hhs.gov/programs/opre/welfare_employ/enhanced_hardto/reports/telephone_care/telephone_care.pdf

[\[Back to Top\]](#)

JUVENILE JUSTICE

Improving the Effectiveness of Juvenile Justice Programs: A New Perspective on Evidence-Based Practice. By Mark W. Lipsey, Peabody Research Institute, Vanderbilt University, and others. (Center for Juvenile Justice Reform, Georgetown University, Washington, D.C.) December 10, 2010. 68 p.

[“Juvenile justice systems in the United States have long struggled with the inherent tension between their role in meting out punishment for violations of law and their role as an authoritative force for bringing about constructive behavior change in the wayward youth who commit those violations. Our view is that the overarching and intertwined goals of juvenile justice should be ensuring public safety—protecting the public from any additional harm caused by juvenile offenders—and altering the life trajectories of those juveniles to not only reduce further criminal behavior but to improve their chances to prosper as productive citizens. Attaining those goals requires the capability to control behavior in the short term and the means to induce self-sustaining behavior change that will persist after youth are no longer under court supervision.”]

Full text at:

<http://cjjr.georgetown.edu/pdfs/ebp/ebppaper.pdf>

[\[Back to Top\]](#)

Substance Use and Delinquent Behavior among Serious Adolescent Offenders. By Edward P. Mulvey, University of Pittsburg, and others. *Juvenile Justice Bulletin*. (Office of Juvenile Justice and Delinquency Programs, Rockville, Maryland) December 2010, 16 p.

[“The nexus between substance use and offending during adolescence has important implications for juvenile justice interventions. Many of the adolescents who get in trouble with the law have problems with substance use, and their offending is tied to their involvement with drugs or alcohol. Gaining a deeper understanding of the dynamic ebb

and flow of these behaviors is critical to refining treatment approaches and more effectively targeting prevention efforts for adolescent offenders. The right intervention at the right time in the development of these offenders could forestall a lifetime of substance use and offending that fuel each other in a destructive pattern.”]

Full text at:

<http://www.ncjrs.gov/pdffiles1/ojdp/232790.pdf>

[\[Back to Top\]](#)

SUICIDE PREVENTION

‘Repetition of suicide attempts across episodes of severe depression: Behavioural sensitisation found in suicide group but not in controls.’ By Louise Bradvik, and Mats Burglund, Lund University, Sweden. IN: BMC Psychiatry, vol. 11, no. 5 (January 7, 2010). pp. 1-24.

[“Depressed suicide victims are known to have made more suicide attempts during their life-span as compared to living depressives. A behavioural sensitisation or kindling model has been proposed for suicidal behaviour, in accordance with a sensitisation model of depressive episodes. The aim of the present study was to test such a model by investigating the distribution of initial and repeated suicide attempts across the episodes in suicides and controls with a unipolar severe depression.

Method

A blind record evaluation was performed of 80 suicide victims and controls admitted to the Department of Psychiatry between 1956 and 1969 and monitored to 2006. The occurrence of initial and repeated suicide attempts by order of the depressive episodes was compared for suicides and controls.

Results

The risk of a first suicide attempt decreased throughout the later episodes of depression in both suicides ($p < .000$) and controls ($p < .000$). The frequencies of repetition early in the course were actually higher in the control group ($p < .007$). After that, the risk decreased in the control group, while the frequencies remained proportional in the suicide group. At the same time, there was a significantly greater decreased risk of repeated attempts during later episodes in the control group as compared to the suicide group ($p < .000$). The differences were found despite a similar number of episodes in suicides and controls. Moreover, similar rates of adequate treatment of the episodes in suicides and controls have previously been found. Conclusion: Repeated suicide attempts in the later episodes of depression appear to be a risk factor for suicide in severe depression. This finding is compatible with a behavioural sensitisation of attempts across the depressive episodes, which seemed to be independent of a corresponding kindling of depression.”

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244x-11-5.pdf>

[\[Back to Top\]](#)

“Suicidal Intention, Psychosocial Factors, and Referral to Further Treatment: A One-Year Cross-sectional Study of Self-poisoning.” By Mari A. Bjornaas, Oslo University Hospital, Norway, and others. IN: *BMC Psychiatry*, vol.10, no. 58 (July 26, 2010) pp. 1-11.

[“Patients treated for self-poisoning have an increased risk of death, both by natural and unnatural causes. The follow-up of these patients is therefore of great importance. The aim of this study was to explore the differences in psychosocial factors and referrals to follow-up among self-poisoning patients according to their evaluated intention.

Methods

A cross-sectional multicenter study of all 908 admissions to hospital because of self-poisoning in Oslo during one year was completed. Fifty-four percent were females, and the median age was 36 years. The patients were grouped according to evaluated intention: suicide attempts (moderate to high suicide intent), appeals (low suicide intent) and substance-use related poisonings. Multinomial regression analyses compared patients based on their evaluated intention; suicide attempts were used as the reference.

Results

Of all self-poisoning incidents, 37% were suicide attempts, 26% were appeals and 38% were related to substance use. Fifty-five percent of the patients reported previous suicide attempts, 58% reported previous or current psychiatric treatment and 32% reported daily substance use. Overall, patients treated for self-poisoning showed a lack of social integration. Only 33% were employed, 34% were married or cohabiting and 53% were living alone. Those in the suicide attempt and appeal groups had more previous suicide attempts and reported more psychiatric treatment than those with poisoning related to substance use. One third of all patients with substance use-related poisoning reported previous suicide attempts, and one third of suicide attempt patients reported daily substance use. Gender distribution was the only statistically significant difference between the appeal patients and suicide attempt patients. Almost one in every five patients was discharged without any plans for follow-up: 36% of patients with substance use-related poisoning and 5% of suicide attempt patients. Thirty-eight percent of all suicide attempt patients were admitted to a psychiatric ward. Only 10% of patients with substance use-related poisoning were referred to substance abuse treatment.

Conclusions

All patients had several risk factors for suicidal behavior. There were only minor differences between suicide attempt patients and appeal patients. If the self-poisoning was evaluated as related to substance use, the patient was often discharged without plans for follow-up.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-10-113.pdf>

[\[Back to Top\]](#)

VETERANS

“National Guard Families after Combat: Mental Health, Use of Mental Health Services, and Perceived Treatment Barriers.” By Lisa A. Gorman, University Outreach and Engagement-National Guard Project, and others. IN: *Psychiatric Services*, vol. 62, no. 1 (January 2011) pp. 28-34.

[“National Guard forces have deployed in large numbers to Iraq and Afghanistan since September 11, 2001. The purpose of this cross-sectional study was to assess mental health symptoms, utilization of mental health services, and perceived barriers to service use among National Guard members and their significant others (including spouses and others with whom they share a committed relationship) from a Midwestern state. *Methods:* Participants were recruited for the study at military- sponsored reintegration workshops, which took place 45–90 days after service members’ return from deployment. A sample of 332 National Guard members and 212 significant others volunteered to complete a survey that assessed mental health symptoms, service utilization, and barriers to treatment. *Results:* Forty percent of National Guard members and 34% of significant others met the screening criteria for one or more mental health problems. Of those meeting the criteria, 53% reported seeking help of some kind (50% of soldiers; 61% of significant others). Stigma associated with mental health care and concerns about service utilization appearing on military records ranked high as barriers among service members. Concerns about the influence of mental health issues on career advancement were of note. For significant others, barriers included the costs of mental health care, trouble with scheduling appointments, difficulty in getting time off work, and not knowing where to get help. *Conclusions:* The mental health effects of combat on the soldier and his or her significant other remain a challenge for National Guard families, who often reside in communities that show little understanding of the psychological costs of war. Barriers remain for mental health service utilization.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/62/1/28>

[\[Back to Top\]](#)

“Serving Those Who Served: Retention of Newly Returning Veterans from Iraq and Afghanistan in Mental Health Treatment.” By Ilan Harpaz-Rotem, Ph.D. and Robert A. Rosenheck, Yale University of Medicine. IN: *Psychiatric Services*, vol. 62, no. 1 (January 2011) pp. 22-27.

There are growing concerns about the mental health status of returning veterans from the recent conflicts in Iraq (Operation Iraq Freedom [OIF]) and Afghanistan (Operation Enduring Freedom [OEF]) and about retention in mental health treatment of veterans with posttraumatic stress disorder (PTSD). This study obtained data from veterans who had a new diagnosis of PTSD from fiscal year (FY) 2004 to FY 2007 and determined whether retention in PTSD treatment and the number of mental health visits were comparable among OIF-OEF veterans and veterans from other service eras. *Methods:* Data from the Department of Veterans Affairs and the Department of Defense were combined to identify veterans who were newly diagnosed as having PTSD (N=204,184)

and their service era. Survival analysis assessed dropout from mental health treatment within one year from initial diagnosis, and Poisson regression assessed the association between war era and number of mental health visits. *Results:* Although a smaller proportion of OIF-OEF veterans than Vietnam-era veterans remained in treatment for more than one year (37.6% versus 46.0%), when the analyses adjusted for demographic characteristics and comorbid diagnoses, OIF-OEF veterans were less likely than Vietnam-era veterans to discontinue psychiatric treatment for PTSD within one year. OIF-OEF veterans attended fewer mental health visits than Vietnam-era veterans did (8.15 versus 13.37). However, multivariate analysis indicated that, after the analyses adjusted for confounding factors, OIF-OEF veterans had significantly more visits than Vietnam-era veterans associated with PTSD treatment. *Conclusions:* Retention and numbers of visits were found to be lower among OIF-OEF veterans primarily as a function of age and comorbid conditions and not as a function of the particular war era. Interventions should be designed to target specific barriers to care that may interfere with continued engagement in mental health services.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/62/1/22>

[\[Back to Top\]](#)

NON PROFIT RESOURCE CENTER-GRANT WRITING

[“Our mission is to enhance the resources and improve the management of nonprofit organizations, primarily within California's northern Central Valley and Sierra Nevada regions.

We invite you to visit us often to find resources that will help your nonprofit grow stronger and be more successful -- from information on training opportunities, consultation and technical assistance, to building connections with your peers.

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More information about grant-writing at:

<http://www.nprcenter.org/>

[\[Back to top\]](#)

CONFERENCES, MEETINGS AND SEMINAR

Reinvigorating Primary Care in the Form of Patient-Centered Medical Home

January 18, 2011

5:00pm Reception and Registration

5:30pm Presentation
UC Davis Medical Education Building
4610 X Street, Room 1222
Sacramento, CA

“An evening with Robert Reid, M.D., M.P.H., a primary care physician and an investigator at the Group Health Research Institute, to learn how a large integrated healthcare system transformed primary care delivery using the patient-centered medical home model. Dr. Reid's research expertise revolves around organization, design, and financing to promote uptake of efficient, patient-centered evidence based care. Since 2007, Dr. Reid has led the evaluation of a patient-centered medical home (PCMH) prototype at Group Health Cooperative and is currently evaluating its spread across Group Health's entire health care delivery system.”

For more information:

<http://www.ucdmc.ucdavis.edu/famcommed/images/rs/Snively2.pdf>

The 25th Conference Annual San Diego International Conference on Child and Family Maltreatment.

January 22-28 2011
Town and Country Resort and Convention Center
San Diego, California

[“The San Diego Conference focuses on multi-disciplinary best-practice efforts to prevent, if possible, or otherwise to investigate, treat, and prosecute child and family maltreatment.

The objective of the San Diego Conference is to develop and enhance professional skills and knowledge in the prevention, recognition, assessment and treatment of all forms of maltreatment including those related to family violence as well as to enhance investigative and legal skills. Issues concerning support for families, prevention, leadership, policy making and translating the latest research into action are also addressed.”]

For more information:

http://www.sandiegoconference.org/Documents/2011conf/11SDConf_brochure-1.pdf

[\[Back to top\]](#)

Personality and Temperament: The Building Blocks of Behavior. Annual Meeting
American College of Psychiatrists.

February 23-27, 2011.

Fairmont Hotel
San Francisco, California

[“The American College of Psychiatrists’ Annual Meeting offers Members a chance to exchange information and participate in high-quality continuing medical education programs in a relaxed setting. More than 50 percent of the Members attend the Annual Meeting.

The College organizes each four-day Annual Meeting around a central theme. Typically, the program format includes large general sessions and smaller breakout courses. Faculty members are leading scholars, clinicians, and researchers drawn from The College and the profession at large.”]

For more information:

<http://www.acpsych.org/meetings-and-news/annual-meeting>

[\[Back to top\]](#)